IMMUNIZATION PROVIDER PROFILE

State Form 50201 (R5 / 8-09)
Indiana State Department of Health, Immunization Program

INSTRUCTIONS: This form must be completed for individual public and private facilities approved by the State for receipt of vaccines through the Indiana State Department of Health (ISDH) Immunization program. This document provides shipping information and helps ISDH determine the amount of vaccine to be supplied through the program. The form also may be used to compare estimated vaccine needs with actual vaccine supply. ISDH Immunization Program maintains this record on file with the Provider Agreement (State Form 52697), *and it must be updated annually or more frequently if: (1) estimates of children served changes, or (2) the type of the facility changes.*

☐ New Provider ☐ Existing Provider ☐ Medical Officer Change Provider PIN Number _____

A. Provider Information

Facility Name _____ Physician License Number _____

Medical Officer Name _____ Title _____

Shipping Contact Name _____ Title _____

Vaccine Delivery Address _____
(Number and street, no P.O. Boxes)

City _____ ZIP Code _____ County _____

Telephone _____ Fax _____

Email Address _____

Preferred Vaccine Delivery Days/Time _____

No Vaccine Delivery Days/Time _____

B. Is this facility a Medicaid provider? ☐ Yes ☐ No

C. Type of Facility *(Check one only)*

☐ Public Health Department (10) ☐ with Delegation of Authority ☐ Private Practice (Individual or Group) (20)

☐ Hospital ☐ Public (12) ☐ Private (22) ☐ Community Health Center or Maternal Child Health Clinic (16)

☐ Federally Qualified Health Center or Rural Health Center (15) ☐ Other Private (24)
(Must have HRSA designation on file with VFC)

D. For a 12-month period, please enter below the estimated number of children who will receive vaccinations at your facility, by age and eligibility category. *Do not count a child in more than one category.*

Eligibility Category	Birth to 1 year old	1-6 years old	7-18 years old	Total
Enrolled in Medicaid				
No Health Insurance				
American Indian or Alaskan Native				
Underinsured*				
Fully Insured**				
Total				

Underinsured children are only eligible through the VFC Program if vaccinated at a Federally Qualified Health Center, Rural Health Center, or Local Health Department with Delegation of Authority. Fully insured children are not eligible to receive VFC vaccine.*

E. Type of data used to develop the above estimate.

☐ Previous year doses administered ☐ CHIRP ☐ Medicaid Data ☐ Provider Encounter ☐ Other _____

Signature _____ Date *(month, day, year)* _____
(Medical Officer or Contact Person listed in Section A.)

F. Mailing Contact

☐ Same as Shipping Contact information provided in Section A.

Mailing Contact Name _____ Title _____

Mailing Address *(number and street)* _____

City _____ ZIP Code _____ County _____

Telephone _____ Fax _____

Email Address _____

G. Additional Practitioners

Please list the names and medical license numbers of all other health care providers within the practice who may prescribe vaccine.

Physician Name	**Physician License Number**	**Title**